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Maria Lusiani

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Formal planning and the reshaping of public sector professional work *

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MARIA LUSIANI

Department of Management

University of Venice

Abstract:

This paper deals with the 'managerialization' of public sector professional work. Specifically, it will focus on the role of formal planning practices (as expressed in strategic planning, project management and budgeting practices) in changing public sector professional work. Planning and accounting are at the heart of public sector reforms, responding to a logic of having public service professionals transparent on what they do, on how they pursue their goals, and accountable on the use of resources and on results. Thus planning and accounting practices have been transferred from private sector management models to public, professional organizations. Yet public sector professional organizations can be conceived as a pluralistic setting characterized by diffuse power, fragmented objectives and knowledge-based and are deeply embedded in public administration regulatory logics: how can management models deriving from private, hierarchical firms be applied to the specificities and complexities of public, pluralistic settings? What is the specific meaning of formal planning practices in such complex contexts?
Based on a qualitative, single case study design, this paper will show how the planning system (in its manifestation of strategic planning, project management and budgeting) applied in a public hospital apparently 'fails' when its deliberate role of serving as a tool for decisions is considered. Yet it is widely in use and widely accepted by professionals as well. Conclusions on the value of formal planning when other emergent roles are taken into account will be discussed.

Keywords: Planning, public sector, professionals, managerialism.

Correspondence to:

Maria Lusiani Dept. of Management, Università Ca' Foscari Venezia
San Giobbe, Cannaregio 873
30121 Venezia, Italy
Phone: [+39] 041-234-8725
Email: maria.lusiani@unive.it

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Introduction

Professional service organizing in the public sector has been changing substantially in the past two decades under the pressure of New Public Management trends. New Public Management reforms since the 1980s and 1990s had public, professional organizations challenge many of their organizational and governance arrangements in the name of efficiency and accountability to have "public services that work better and cost less" (Panozzo, 2000). This involved major changes that started to reshape jurisdictions and contents of professional work, and that are still going on.

The introduction of formal planning practices is part of these managerial innovations involving new roles, new organizational processes and new meanings for professional workers. Indeed, planning lies together with accounting at the heart of public sector reforms, responding to a logic of having public service professionals rational in their decision making, transparent on what they do, on how they pursue their goals, and accountable on the use of resources and on results.

How does professional work change accordingly? Is this managerial innovation changing professional work and how?

The introduction of managerial innovations in public and professional services has been the object of many studies in public management research and in the sociology of professions. This research has explored different patterns of how professional work has changed in response to managerial reforms: resistance by professionals (e.g. Harrison & Pollitt, 1994; Kithcener, 2000); decoupling – i.e. the rhetorical and ritualistic adoption of new language and tools by professionals, not coupled with a change in their practice (e.g. Broadbent & Laughlin, 1998; Farrell & Morris, 2003; McGivern & Ferlie, 2007); hybridization – i.e. the blurring of boundaries between professional and managerial values (e.g., Llewellyn, 2001; Noordegraaf, 2007; Levay & Waks, 2009). However, most of this research has investigated the introduction of accounting and auditing practices or the introduction of new managerial roles, or new organizational structures. Indeed, curiously, the role of formal planning in such contexts is an issue that remains under-investigated in the literature: the long debate on formal planning in strategy research devoted scant attention to its diffusion in the public sector, and public sector studies have scrutinized the introduction of other management tools in professional work, but very little formal planning itself. In fact, little is known on the actual meaning of formal planning in public, professional services (Ferlie, 2002; Stewart 2004).

I try to reconstruct this meaning from the context, by exploring how professionals appropriate formal planning in their professional practice and how they respond to it. Empirically, I draw on a case study of an Italian public hospital which has been setting particular emphasis on the

introduction of a formal planning system, trying to empower professionals by involving them in strategizing through the development of a 'planning course' composed of strategic planning, project management and budgeting practices. For the centrality given to these topics, this seems a suitable setting to understand the role of formal planning in changing professional work.

Exploring how professionals are engaging with these new practices may contribute to our understanding of how professional service organizing is being re-invented or re-constructed in the field. In particular, this may extend the debate on profession-management tensions in the changing public sector to a management discourse that was under-explored within this literature (formal planning), hence launching a bridge between two areas of research that have followed parallel evolutions (strategy/planning on the one side and control/acouning on the other) – a curious academic anomaly when confronted with the empirical reality. By doing so it also contributes to the debated question of the apparently reassembling dualism between managerial and professional values.

The paper starts with a review of the literature on profession-management tensions in the changing public sector. It then describes the empirical setting and methods, before presenting the findings and discussing them within the relevant literature on and the implications for future research.

Profession-management tensions in the changing public sector

The introduction of managerial techniques in public and professional contexts has been the object of many studies in public management research and in the sociology of professions. Indeed, a prominent branch of studies developed around the phenomenon of the so called New Public Management (Hood, 1991). The earlier contributions in this field were preoccupied with providing macro overviews on the features of New Public Management, how it originated, and how it diffused and articulated in different national contexts (e.g. Hood, 1995; Gruening, 2001; Flynn, 1997, 2000). Other contributions critically questioned the actual managerial changes at the organizational level (e.g. Stewart & Walsh, 1992; McNulty & Ferlie, 2004), or – sharing an even more micro focus – in the actual professional work within public organizations (e.g. Kitchner, 2000; Fitzgerald & Ferlie, 2000; Ezzamel et al., 2007).

This latter stream builds on the disciplinary field of the sociology of professions as developed in the 1960s with the works by Richard W. Scott, Richard H. Hall and others, and systematized by the influential treatise by Abbott (1988). It is based on one of the main theses of the sociology of professions: the 'management-professionalism' polarization. Professional work is characterized,

among other attributes, by the quality of 'autonomy', i.e. by the fact of being only limitedly subjected to managerial regulations, because of the status of 'expert' of professionals (Hall, 1968; Harrison, 1976). Hence in the sociology of professions managers and professionals embody distinct identities differing by values, language, culture, frameworks, and rules of the game (Shortell, 1991). These two social identities are positioned in a relation of natural conflict, in that each one is moved by divergent objectives, often competing for the same scarce resources in a continuous tension for dominance (Harrison, 1976).

Departing from this assumption of conflict between managerial and professional identities, the phenomenon of the managerialization of public, professional services is interpreted as 'de-professionalization' (Haug, 1993) or 'colonization', i.e. in terms of a profound change in the identity and in the status of professionals in favour of an increased managerial control on professional work. Several empirical studies developed to investigate professionals' responses to this colonizing process. Overall, three main patterns of professionals' response to managerialization emerge: (a) resistance, (b) decoupling, and (c) hybridization.

Table 2 offers a synthetic review of these studies. For each contribution it reports the managerial innovation the study is focused on, the professional context where the research was conducted, and the main finding. The contributions are grouped according to the main pattern that seems to emerge from the empirical findings[1].

(a) Resistance

A typical response of professionals to public sector transformation is one of resistance, i.e. a more or less conscious reaction to the rationality of management tools in the name of the specificity and the complexity of professional work, often leading to a sort of war between civilizations and a role contrast (management *versus* professionalism).

This was a point first made by Harrison and Pollitt (1994) in their book on the analysis of management pressures in general (cost control, quality evaluation, consumerism, market relationships) on work and organization in the British National Health Service (NHS). Because managers' decisions need clinical legitimacy, doctors had indeed a large space to resist managerial innovations. They also predicted that the control of professional work would remain the central argument in the future of the NHS.

This prediction was confirmed by several subsequent studies. For example, Kitchener (2000), questioning the alleged argument of 'de-professionalization' in the healthcare sector, found that

[1] Whenever a contribution acknowledges several patterns of professionals' response to managerialization, its reference is repeated in different sections of the table.

doctors taking up a clinical director role protected clinical autonomy in fact and resisted the managerial colonization over the clinical practice. Similarly, Thorne (2002) framed the managerialization of the medical profession in terms of fight for power and control, where professionalism and management attack one another by imposing technical knowledge or structural changes. Management acquires increasing centrality in healthcare organizations, but medical professionals struggle to safeguard their autonomy, claiming that only they can be "customer oriented" and "front line" in a way that managerial knowledge cannot.

The reason why to expect professionals' resistance to management reforms had been advanced by Laughlin and colleagues (1992) in their early exploration of the key historical and contextual reasons for general practitioners' resentment for the introduction of accountability. They found that the reason lied, on the one hand, in the generic (at best) or harmful (at worst) contents of the reforms respect to general practitioners' values, and, on the other hand, in the perceived inappropriate intrusion into medical autonomy by a Government who was previously enabling such freedom in fact.

However, other scholars reported a more composite array of professionals' responses where resistance plays a role, but it is not the only one. For example, Fitzgerald and Ferlie (2000) investigated the impact of quasi-market reforms in the healthcare sector in two longitudinal studies, exploring in particular how medical-managers perceived their new roles and pursued an integrated medical-management agenda. Indeed, their main finding is that professionals did perceive that their position and freedoms had been eroded and frequently blamed 'management' for those changes. However, not all professionals resisted change: some lost power, others acquired more power, and several contextual factors helped explaining such varying impact and power shifts. Likewise, Doolin (2002) in his study on the decentralization and the creation of semi-autonomous units in New Zealand hospitals argued that the enterprise discourse developed thereon shaped some new enterprising behaviour in medical practice, but not in a deterministic way. Instead, he found three patterns of typical responses among clinical professionals: some linear adaptation to the new circumstance; some clear resistance to change, where professional identity kept being derived from the essence of clinical work in contrast to an enterprise discourse; some overt resistance to enterprise discourses, but an absorption of some enterprise behaviour in the practice, with a balance between traditional professional values and identity and new managerial ones.

(b) Decoupling

Some scholars started to point out that frequently professionals were not overtly resisting public sector managerialization, but rather adopted the new management innovations ceremonially as new

procedural accomplishments, or as an additional working level that nevertheless remains detached from the professional practice, without a real change in the values and in the substance of their everyday work. This pattern of responses was by many labelled 'decoupling' (Ezzamel et al., 2007), borrowing the term from the neo-institutional literature that defined it as ritual and organizational hypocrisy that leaves people's beliefs unchanged (Di Maggio, 1988).

This finding was reported for example by Whittington and colleagues (1994) in a study on the impact of managerialism on medical and R&D professionals, where professionals accepted the new managerial responsibility in a defensive way; in particular, clinical directors where appropriating and mobilizing a market discourse with claims of "service quality", "market demand", "the citizen as a customer", but these showed to be only rhetorical claims, while their working practice did remain unchanged. Broadbent and Laughlin (1998) found a similar pattern and a peculiar solution in clinical professionals' reaction to what they called "accountingization" of professional work, and spoke about "subtle resistance" or "superficial absorbing": since professionals perceived accounting as an inappropriate programming of tasks and an intrusive disturbance impacting their core activities, they reacted by setting up an "absorbing group" to take up the change, while the core front line activities were not affected, hence limiting (without resisting it) the power of accounting-related initiatives to bring about social change. One of the empirical findings of Fitzgerald and Ferlie's (2000) study is the evidence of some decoupling between form and substance of professional work and, in particular, between the rituals of the budgeting, and the real driver for decisions (which continued to be traditional knowledge on the quality and outcomes of care).

Similar patterns of decoupling were confirmed also in several other empirical studies and some authors referred to them as "game playing" with new discourses – like in Farrell & Morris's (2003) study on accountability innovations in the education sector – or "mock ritual" and "playing tick box game" (McGivern & Ferlie, 2007) as far as professionals' engagement with the auditing practice in a healthcare organization was concerned.

(c) Hybridization

Recently, scholars started to acknowledge a third pattern of professionals' response to the managerialization trend: 'hybridization', i.e. a non conflictual absorption and re-elaboration of new managerial values within traditional professional work, leading to a blurring of boundaries between management and profession. Noordegraaf (2007) revisited the notion of professionalism in ambiguous contexts, proposing to go beyond dualisms and positing the existence of hybrid professional-managers. In his view, the definition of profession is not an *a priori*, but is a relational concept, also relative to time and space.

Indeed, several studies had reported patterns close to this notion of hybridized professionalism even before. Among the earliest contributions, Dent (1995) had scrutinized the re-organization of the NHS in Britain towards forms of quasi-market and quality assurance system, confronting state policy with local practice in a case study in a small, new hospital. In this new-born and peculiar context he could witness that senior medical and nursing personnel were adapting and developing their own autonomy and flexibility in a new way – not resisting, nor superficially absorbing managerialism. One of the empirical findings of Fitzgerald and Ferlie's (2000) work was a pattern of hybridization too, as far as some clinical directors were understanding and empathizing with managerial innovations. Llewellyn (2001) expressed this same concept in different terms: in his study on clinical directors' perception of their own new role, he found that "a third domain is formed that represents a new convergence betwen two sets of ideas: […] the new domain […] locates a new form of organizational expertise to which neither of the two original sets of players have full access" (:602). In other words, from a conflict between management and profession a brand new discourse is formed by mediation. In a similar study on the role of clinician managers in New Zealand, Doolin (2001) found that the establishment of this role entailed a combination of clinical knowledge and of credibility with management expertise, which was not a process of de-professionalization, but rather a renegotiation of the perceived boundaries between medicine and management as clinicians became incorporated into the new structure as hybrid managers.

Hybridization was a response found not only in the investigations on new medical-manger roles, but also by other studies that explored the introduction of new managerial practices more in general. For example, Hoque et al (2004) explored the introduction of auditing and budgeting in a hospital and found a high degree of absorption of the new managerial culture of managing by goals and targets, but only limited to nurses – not doctors. Ezzamel and colleagues (2007) addressed the issue of accountability in a school and found a combination and an overlapping of a professional and a regulatory (financial) accountability in the way professionals engaged with it. Likewise, Levay and Waks (2009) reported the existence of a third way between resistance and decoupling as far as auditing in hospitals is concerned (where professionals combine managerial standards and professional values, in a sort of "soft autonomy").

[Table 1]

Taken together, this review shows that the classic management-professionalism divide has been challenged substantially. The research that investigated professionals' responses to managerialization tended to find evidence of dualism and resistance especially in the earlier studies

of the 1990s, while more recent studies recognized much softer responses ranging from decoupling or superficial absorbing to – increasingly – a convergence on blurred roles where professionals act both as expert and as accountable decision makers. This might reflect both a shift in academic thought in this field, questioning the perhaps too rigid notion of profession in classical sociology (Golden et al., 2000; Noordegraaf, 2007), but it might also reflect some shift in the practice, as a new view of management in general (Grey, 1999), and of public management in particular, consolidated. In other words, "the initial question about how managers are differentiated from non-managers seems to be disappearing under the effects of a discourse which stresses the ways in which 'we are all managers'" (Grey, 1999). However, whether this is the case remains debatable.

This review also shows that research has focused the attention on the introduction several managerial practices, like accounting (e.g., Llewellyn, 2001; Thorne, 2002; Ezzamel et al.,2007), auditing (e.g., McGivern & Ferlie, 2007; Levay & Waks, 2009), new managerial roles or structures (e.g., Kitchener, 2000; Doolin, 2002), and quasi-market reorganizations (e.g., Fitzgerald & Ferlie, 2000). Curiously, the issue of formal planning is not much scrutinized, despite the fact that planning – as coupled with notions of accountability and control – lies at the heart of public sector managerial reforms (Ferlie 2002).

This paper intends to further investigate profession-management tensions by exploring the introduction of formal planning in public sector professional work. How is professional work changing when the incursion of formal planning in professional practice is concerned? What are professionals' responses to a discourse of formal planning?

This may advance our understanding of how complex organizations like public, professional services re-conceive and re-construct themselves under today's growing (managerial) change needs, questioning the profession-management dualism and extending this debate to formal planning. In turn, this can shed some light on the role of formal planning in public sector professional work.

Methods

This is a qualitative, in-depth study, based on a single case. The study shares with all single case design studies the obvious limitations of generalizability of results, but acquires in depth and richness of data, thus suiting the specific purpose of this research.

I combine discourse analysis (especially applying content analysis as a main technique) with ethnographic analysis, i.e. I ground my study on the analysis of both text and context, in order to access both the discourses and the cultural understandings of non discursive processes, as

recommended by recent methodological contributions on discourse analysis (Hansen, 2006; Barry et al., 2006).

Empirical setting and contextual background

The research setting is an Italian public hospital (Ulss9) which is going through a process of change in application of the managerial reforms that reshaped the national health system in the 1990s (introducing notions of greater autonomy, accountability, comprehensive planning, and new managerial roles for clinicians). In particular, in recent years – and especially under the two mandates of the present General Director – Ulss9 dedicated substantial efforts in the development of a complex system of planning and control, named the *'planning course'*: strategic planning practices were introduced, bottom-up project management activities among the professionals were stimulated, and clinical budgeting practices were enhanced; efforts to align strategic plans, bottom-up projects, and budgets in a unique path are being made. The deliberate logic of the planning course is to empower professionals by involving them in strategizing through the development of planning, project management and budgeting practices. In order to pursue this goal, a Planning Office was established to support and field-train clinicians in project management and budgeting.

I selected Ulss9 for two main reasons: first, the special emphasis devoted to formal planning by this organization in recent years; second, the fact that I had the chance to get easily access to the field via a key informant. Indeed, for the centrality given to formal planning, this seemed to me a suitable setting to understand the meaning of a planning discourse in practice in professional work. Moreover, the key informant who provided me with access was the Chief Planning Officer. This allowed me to obtain full access to all organizational documents concerning formal planning and other archives, to shadow the work of Planning Officers throughout the whole unfolding planning course, and to conduct interviews with both professionals and top managers. In particular, being enabled to shadow the work of Planning Officers with clinicians was a unique opportunity to explore processes of creation, diffusion, appropriation and use of a formal planning discourse among professionals.

Data gathering

I collected data from three main sources. First, documents: I collected all triennial strategic plans and all annual operational plans since 1996 (i.e. since when the hospital started to produce them as part of the application of the health care reform). I collected and processed also several other organizational documents, like organizational reports, internal regulations, power point or other kind of presentations posted on the intranet, and the operational units' budget files. These archival

documents provided qualitative, longitudinal data on which formal planning Discourse entered this organization, when, and how it developed throughout time. This served as the baseline of analysis.

Second, fieldnotes and – whenever possible – transcripts of recorded material gathered through participant observation of the processes in which professionals engage with planning practices. This concerned several processes related to strategic planning, project management, and budgeting processes. It included one-to-one interactions between professionals and the management officers from the Planning Office, and several meetings. Overall, my participant observation activity covered 8 months (October 2009-May 2010), for an average of 2 full days a week in the field (an amount of over 300 hours of direct participant observation). I took on-site fieldnotes and used a formal research diary in parallel to record notes, observations, and interpretations. Participant observation was perhaps the most important aspect of my data-gathering strategy, especially for understanding the local praxes of formal planning (tracking all interactions between Planning Officers and professionals, seeing how the planning course was enacted in practice), but also for providing a means to bridge among and make sense of the different informant views.

Third, interviews: I conducted three rounds of interviews to access the views of local actors (both management staff and professional staff) on formal planning. As for the management staff, I carried out interviews with Planning Officers and with the Top Management. As for the professional staff, I interviewed all clinical directors of the hospital. Overall I conducted 21 formal interviews, plus numerous informal conversations. This study is especially based on the semi-structured interviews to all (12) clinical directors of the hospital. Each interview was purposely unstructured in the first part (where clinical directors were only stimulated to narrate their job and to reflect upon how it changed throughout time, if ever): in this part of the interview I was mainly interested in understanding how the actors made sense of their work, and whether, how and how much this spontaneously included a management discourse and – in particular – notions of planning/projects/budgets. The second part of each interview was purposely more structured: the participants were stimulated to focus their narrative on the practices of strategic planning, project management, and budgeting. In this part of the interview I was interested in capturing the actors' own view of each one of these practices.

Analytical procedure

First, I reviewed the official, formal organizational narrative on the planning system at place. Second, I provided a thick description of all the planning, project management and budgeting processes as I observed them in the field, and confronted it with the official, formal narrative. Third, I coded all data by identifying themes and overarching categories through all sources of qualitative

data. I used the Nvivo software as a data management platform to import and organize data, in order to better discipline (yet not constrain) the analyses that followed. Fourth, I conducted content analysis on all coded data.

During my direct experience in the field throughout the unfolding of the planning course and during the interviews with the clinical directors of all hospital departments, I had the chance to appreciate not only how professionals actually make sense of formal planning in their everyday work, but also how they respond to it: whether they tend to resist it in their practice, or whether they have rather come to appropriate it by sharing its rationale and tightly sticking to it; or else even sharing its rationale in principle but not willing or being able to really engage with it in the practice. In this paper I will especially focus on these findings.

The 'planning course'

In the years – and especially under the two mandates of the present General Director – Ulss9 dedicated substantial efforts in the development and in the improvement of a complex system of planning and control, named the 'planning course' (*'il percorso di programmazione'*) for "managing the process of innovation and of continuous change of the organization" (Bilancio di Mandato 2008-2009). Over time Ulss9 developed the conviction that "a clear definition of the objectives, the indicators to measure them, and of the strategies to reach them is a fundamental activity involving all organizational levels" (ibidem).

The planning course is then articulated into long term **strategic planning** (with the 'Piano Attuativo Locale' – PAL) and its annual specification ('Documento di Direttive', or annual plan); in the development of organizational **projects** by any professional or other operators at any organizational level; and in the negotiation and monitoring of each unit's **budget** throughout the year, on the basis of periodical reports. The following two figures illustrate the temporal sequence and the structure of the planning course espoused at Ulss9.

[Figure 1]

[Figure 2]

The strategic plan (PAL) is "the basic document for the organization's planning" (Bilancio di Mandato 2008-2009). In the strategic plan a few triennial strategic goals are defined and for each one several triennial strategic levers are identified; further, under every strategic lever specific objectives are outlined for each one of the three years concerned "expressed in the most operational

and concrete form as possible" (ibidem). The strategic plan (and, in particular, its annual breakdown – the 'Documento di Direttive') is diffused throughout all units. The goal is "to provide all department directors and heads of units with a guide to make their annual activity consistent with the overall organizational strategy" (ibidem).

The plan is "the starting place for the budgeting process by accountable centres" (ibidem). In the budgeting process every unit's head, through the department director, negotiates with the General Direction the specific activity objectives for the operational unit, in accordance with the goals, levers and objectives stated in the plan.

Moreover, since 2003 Ulss9 adopted a project management methodology with the purpose to "correlate the organizational planning process and project management as a tool and a way to realize the goals stated in the plans" (ibidem). Therefore, every unit's head is expected not only to negotiate the budget objectives according to the plan, but also to propose one or more projects that allow the attainment of those goals. In the project management process, the project chiefs are expected to involve other professionals, by sharing the objectives in order to favour a wide participation.

In sum, strategic planning, project management, and budgeting at Ulss9 are to be considered as intertwined processes that altogether compose the planning course and that are linked to each other as follows:

1. link between the strategic planning and the project management processes: the strategic planning process results in the formulation of a triennial plan (and related annual plans); the objectives stated in the plans should be of inspiration for any employee to propose specific projects; every project has to be explicitly linked to one of the objectives included in the strategic plans; according to the official organizational narrative, *"plans set the goals, projects are the way to reach those goals"*;
2. link between the project management and the budgeting processes: ongoing projects appear in the budget file of every unit concerned; the budget file is explicitly divided into "ordinary activity" and "projects"; hence projects become specific items subject to evaluation in a unit's budget;
3. link between the budgeting and the strategic planning processes: in the organizational official narrative the targets to be met in every unit's budget file should derive from the goals of the plans.

The Planning Office is in charge of following the planning course, especially providing technical support to the professionals involved in every phase.

The Planning Office is composed by three Planning Officers and the Chief Planning Officer (the director of the Innovation, Development, Planning staff department). Two of these officers are in charge of following throughout the planning course and field train professionals from the Hospital structure only (hence they mainly interact with the Hospital direction, 12 Clinical directors, 52 head physicians, 52 nurse coordinators, and all the line doctors, nurses, and other professional technical staff). One officer conducts an analogous work with the Extra-hospital medical activities, the prevention activities, the Social macro-area, and the Administrative macro-area.

Formal planning between discourse and practice in professional work

How is a formal planning discourse translated into practice? How is it reshaping – if ever – professional work?

I tried to identify patterns of responses to a discourse of formal planning in the professionals' accounts, as they emerged from the interviews and in the observed activities. I identified three main categories of responses differing by degree of coupling between action premises and flows of actions. I considered them as three patterns of translation between discourse and practice and I coded all interviews and observational data accordingly. In doing so I was inspired by the extant literature on profession-management tensions in the managerialization processes of public services.

- At one extreme is a response of **Resistance**. In my study I defined Resistance as a pattern of non-translation of a formal planning discourse into practice. I coded under Resistance references showing a negative attitude of professionals towards formal planning, and references showing an overt opposing behaviour (like boycotting) to a formal planning discourse. This theme was developed from the literature on profession-management tensions in the changing public sector, where Resistance indicates a more or less conscious reaction to the rationality of management tools in the name of the specificity and the complexity of professional work, often leading to a sort of war between civilizations and a role contrast (management *versus* professionalism) – e.g., Harrison & Pollitt, 1994; Kitchener, 2000; Thorne, 2002.
- At the other extreme is a response of **Absorption** instead. I defined Absorption all patterns of translation of a formal planning discourse into practice, i.e. a pattern of congruence between action premises and action flows. In this case too I distinguished between attitude (positive attitudes showed by professionals in respect to a strategic planning discourse) and behaviour (alignment/congruence between premises and the unfolding processes). This theme is derived from the literature on profession-management tensions too, where it is more commonly

addressed with the label of Hybridization, i.e. a non conflictual absorption and re-elaboration of new managerial values within traditional professional work, leading to a blurring of boundaries between management and profession (e.g., Llewellyn, 2001; Ezzamel et al., 2007; Noordegraaf, 2007).

- In-between is a response of **Decoupling**. I defined Decoupling all patterns of non complete translation of a formal planning discourse into practice, due to some incongruence between action premises and action flows. In other words, I coded under Decoupling all references showing formal adhesion to a formal planning discourse, though lacking a reflection into practice, both for substantive (merit) and procedural (method) reasons. As far as the procedural decoupling is concerned, I also further distinguished between the decision realm and the process realm. This theme is derived from the literature on professional-management tensions too, where it concerns a ceremonial adoption of the new management innovations as new procedural accomplishments, or as an additional working level that nevertheless remains detached from the professional practice, without a real change in the values and in the substance of the everyday work (e.g., Whittington et al., 1994; Broadbent & Laughlin, 1998; McGivern & Ferlie, 2007).

As it might have been expected, I could witness a wide range of different responses to formal planning rationality among professionals, depending on differing individual attitudes and situations. Yet a close analysis of my interviews and observational data revealed the existence of some patterns in professionals' behaviour when the three components of the planning course at Ulss9 are considered.

Table 2 summarizes the composite situation in highly synthetic terms, as a departure point for some fine-grained analyses. In Table 2 I reported the whole range of professionals' responses to formal planning as they emerged in the field and grouped under the three main patterns I recognized; for each response I retrieved the corresponding references in the interviews and in my own observations and reported their frequency, especially distinguishing between Strategic planning, Project management, and Budgeting.

[Table 2]

Taken together, there is only few evidence of the extreme responses of Resistance (17 references out of 326), and of total Absorption (68 references out of 326) of a formal planning discourse. Most responses concentrate in the in-between zone of Decoupling (241 references). In

other words, for the most is a formal planning discourse only incompletely taken up in practice. It will be of interest to better explore the shortcomings limiting a thorough translation.

A more fine-grained exploration of how professionals do or do not put in practice a formal planning discourse is provided below.

(a) Resistance ("It's all about smoke and mirrors")

In this study I defined resistance as a pattern of non-translation of a formal planning discourse into practice, due to some more or less overt opposing attitude of professionals towards the planning course at Ulss9.

Very little evidence of professionals' resistance to the planning course as a whole can be retrieved from the field indeed. In other words, the translation into practice of some formal planning rationality tends not to be obstructed by the professionals' attitudes towards it. However, some professionals did show some overt opposition to some of the planning processes in a few occasions (17 references under "Resistance" in Table 2). For example, in one of the meetings on the presentation of the new strategic plan, a Clinical director intervened to strongly criticize the Project management process and pointed at it as a "mystification", in that, in his opinion, projects were instrumentally introduced by the Direction to fuel the personnel evaluation and incentive system:

> *Projects have been added to what we already do. You* [the Direction] *evaluate us on that basis: they seem to be added purposely to accomplish the evaluation that you must do at the end of the year. This is to me a mystification.*

Another clinical director attacked the budgeting process in an interview, declaring it *"the biggest fooling around process, and I have been denouncing that since it was introduced"*; similarly, during one of the budget pre-negotiation meetings a head physician exploded in front of his unit's budget file: *"I'm throwing it in the trash can"*. However, both reactions were not moved by some aprioristic opposition to the concept of Budgeting, but rather by some cumulated disillusion concerning its value, as the former professional explicitly stated:

> *Apparently, it is believed that data are not that relevant, because, in the end, if we do or if we don't do the budget negotiation… the money is always the same. But then please don't make us waste our time with this.*

Anyway, most of professionals' scepticism on the planning course concerns the Strategic planning component. According to a clinical director *"it is all about smoke and mirrors"*:

> *Strategic plan is an organizational strategy: the organization diffuses it, but more often than not it is all about smoke and mirrors, because it's about obvious things, I mean, you know those sentences? 'Ulss9*

puts the person in the middle': thank you very much, what else do you want to put? It's obvious, it's healthcare! […] You don't need to write it down after all.

It should be acknowledged that several Clinical directors and head physicians may not themselves resist Strategic planning, but still they report sceptical reactions on Strategic planning from the line professionals, like a clinical director stated in an interview:

You should hear people's comments: they say 'why should we waste our time with this stuff when we have eight beds in the corridor, when we don't have this and that?'

Or like two professionals pointed out in one of the presentations of the Strategic plan:

A head physician to the Medical Director*: You're asking us to raise awareness and diffuse enthusiasm on the strategic plan among our collaborators: this often meets fatigue.*
Another professional*: It's because it's hard to believe those goals.*

Taken together, there is scant evidence of professionals resisting the planning course at Ulss9, but these excerpts are somehow telling: some professionals are critical on the actual value of Strategic planning, Project management or Budgeting, and are especially concerned with the fact that it all constitutes some flimsy activity and a waste of time – something particularly severe in times of resource cuts and increased demand pressure.

(b) Absorption ("there is enthusiasm")

However, the above response is not the mostly shared one in professionals' views and practices as I could observe them in the field. Broadly speaking, the impression is left that formal planning has been quite absorbed as a practice in professional work by now (61 references under "Absorption" in Table 2). In this study by absorption I meant a rather complete translation of a formal planning discourse into professional practice, involving congruence between action premises and action flows in professionals' attitudes and behaviour, when engaging with formal planning processes.

Indeed many professionals' showed to have positive attitudes especially towards Project management (10 references), and Budgeting (13 references) as a Clinical director for example stated in an interview:

I found this [Project management] approach when I arrived here, but I think I would have established it if it weren't present, because I really share it.

On the same tone, during a meeting, another Clinical director replied to one of the other professionals' critique on the value of the Budgeting process (see above). In his intervention he showed his adhesion instead to the logic of Budgeting and indeed an appreciation of an accounting discourse:

I am optimist instead! It seems to me that this is all going in the direction of building a real accrual accounting system which is still absent. It allows espousing our activities with paper. […] The budget becomes more serious, we don't do fake projects any longer; we do serious data, serious projects.

Strategic planning is a planning process that is less understood and appropriated by professionals, compared to the other two. However, although more seldom (6 references by 3 actors only) some Clinical directors definitely showed a positive attitude towards it, as expressed by one of them in very firm terms:

I believe that with Strategic planning we have upped our quality. […] I am positive. I judge it an extremely positive tool".

Beyond professionals' attitudes as they were manifest in the interviews or in many of the observed meetings, absorption of a formal planning discourse by professionals was evident in the actors' behaviour too in many occasions.

In the official view, the contents of the strategic plan should inspire the proposal of *ad hoc* projects by any organizational member (where projects are defined as *"the way to reach the organizational objectives"*). I observed 18 episodes where some professionals were filling in the project proposal file with a Planning Officer. In 7 out of these 18 episodes there was evidence that the professional had clear in mind the strategic goal and lever (and sometimes the operational objective too) his/her project could be linked to, and proposed so to the Planning Officer. An illustration (a professional talking to the Planning Officer while selecting the corresponding strategic goal):

Some of the strategic goals for 2010 concern the establishment of the new functional department of oncology… This project fits in there.

In one case I observed a professional making explicit reference to the (annual) plan when doing the project work progress reporting with a Planning Officer.

We are trying to connect with all the other projects concerning the personnel, because in the plan – if I'm not wrong – there is a goal concerning the personnel, right? So we temporarily stopped with this project, you risk to do something that is not in line with the new goals, you know.

These excerpts then show that a Strategic planning discourse (tightly coupled with a Project management one) is somehow translated into practice by several professionals, as far as they do employ it for their work.

This is something that is even more striking when the Project management process is considered (13 references in this sense in Table 2). The high number of new projects presented every year by professionals indicates that Project management has become a consolidated practice,

as it is well expressed by a comment of the Chief Planning Officer during the project selection meeting:

> *We received over 120 project proposals, of which about 70 from clinicians… So many! It's a sign that the Project management activity is getting a foothold.*

Although he further acknowledged a sort of even 'hyper-absorption' of Project management: *"I don't know how good the sign is though, because you may fall in utopia with too many projects"*.

In general, professionals showed a high degree of commitment when they set up a new project, carried out the work progress reporting of ongoing projects, or when they concluded one. In their interaction with the Planning Officers they often tended to engage in long digressions describing the activities they were carrying on, or planned to, their achievements or their shortcomings. *"There is enthusiasm"* stated a doctor in one of these occasions, *"our next step is to publicize the work we have done with this project, maybe an article on the Ulss9 journal"* stated another doctor when closing up a project. All in all, then, professionals show a highly proactive behaviour when it comes to Project management.

Interestingly, the rationale of the Budgeting process too – although resisted by a minority – is not only accepted but also actively put in practice by many of the professionals (22 references in Table 2). Apparently, the units' budget files and the related quarterly accounting reports have become a working tool for head physicians and clinical directors. It is not unusual that some of them call the Planning Office asking for the new quarterly accounting report or asking for help in analyzing the new budget file (instead of waiting for the Planning Officers' solicitations to undertake these activities). Moreover, in the budget pre-negotiation meetings most doctors showed to know their unit's budget file in detail, as it was also explicitly stated by several actors in the interviews:

> *These are data that we look at. We have the detail of these data and we look at it. I mean, it's not that I spend hours on them; but in the night, you know, when I have some more time, I check these data.*

> *As a Clinical director you have the beautiful opportunity to compare different units, their costs… And it's fun. I'm serious, it is fun indeed!*

What is more, many professionals have become overly exigent on the quality of the budget data. As already suggested in part by the emerged patterns of resistance to the Budgeting process, the professionals' main complaint was not the fact of having their activity represented in accounting terms, but rather concerned the accuracy of those data. As observed in the budget negotiation process, in other meetings and in the interviews, professionals pretended even more precise

accounting representations. The following illustrative example from a budget pre-negotiation meeting shows some pro-active behaviour of a head physician:

> Doctor: *I ask that a project on the quality of accounting information be done!*
> Planning Officer: *There is a project on that this year by the Management Control unit.*
> Doctor: *And why are we not involved in this project? We would like to be involved.*

As a final example of how a Budgeting discourse is translated into practice by professionals, it should be acknowledged that a Clinical director took the initiative of explaining the meaning of the Budgeting process and contents to the whole nurses' team from his department.

> *Yes, because one of the problems is that line doctors and nurses say that very often they have no idea about what has been signed in the budget negotiation process, so they are not aware about the objectives and the projects that should be achieved.*

(c) Decoupling

In the wide range of professionals' responses to some formal planning rationality at Ulss9, both the patterns of Resistance to it (non translation of a formal planning discourse into practice for professionals' opposition) and of Absorption (full translation of a formal planning discourse into practice) constitute some interesting, but extreme cases. As Table 2 reports, the most frequent pattern of response is Decoupling, i.e. some inconsistency between the professionals' inner adhesion to a formal planning discourse and its actual application in the everyday professional practice (241 references overall). My interview and observational data allowed exploring what explained such major pattern. I found that the reasons for a decoupling between intentions and actions are substantive (i.e. concerning the existence/inexistence or the nature of something) and procedural (i.e. concerning the way things are done). I will address the former as 'substantive shortcomings' and the latter as 'procedural shortcomings' of a formal planning discourse.

It is primarily due to procedural shortcomings (169 references overall) and secondarily to substantive ones (72 references) that a formal planning discourse at Ulss9 is not fully translated into practice.

Procedural shortcomings ("A Monopoly game")

Among the procedural shortcomings, some concern the decisional sphere: the 'lack of control on resources' is a severe issue for the Budgeting process (16 references) and is tightly coupled to 'decisions elsewhere' (13 references) – interestingly, this is almost not mentioned for the Project management process.

Virtually all professionals stated in their interviews that the Budgeting process is limited in its potential value by the fact that the budget file is a quantification of a unit's activity and *"not a real budget of resources to be managed",* which makes another clinical director refer to it as a *"Monopoly game"*.

This lack of a direct control on resources for the head physicians and clinical directors also involves that in fact many decisions escape the local control – or at least, escape the Budgeting process in fact. Since there is no real negotiation of any kind of resources during the Budgeting process, it is clear that the decisions 'that count' are taken elsewhere and through other channels.

> *Ours is a virtual budget that more often than not is "all resources being equal". […] Periodically the organization can benefit of new funds, so periodically there may be meetings between the Departments and the Stweard's Office and the Medical Direction, where we try to reason on choices on a priority basis.*

This downplays the role of Budgeting (and, indirectly, the whole planning course indeed) as a decisional tool for professionals in fact.

The procedural shortcomings however mainly concern the process sphere, i.e. how the planning processes actually unfold and how the planning tools are used in practice.

First, there is an issue of 'poor accounting and reporting system', especially for the Budgeting process (55 references), whose value highly depends on the quality of information flows. This shortcoming apparently is the result of a chain of interconnected process inefficiencies: there is a problem of quality of the data that are inputted at the unit level, as the Chief Planning Officer reminded *"garbage in, garbage out"* (sometimes input errors, often inconsistencies in the codes applied, or changes in the coding procedures in the middle of the year, etc.). Then there are problems in the data management system which can occur at the IT services level (e.g., a difficult interface between the heterogeneous softwares in use to receive, elaborate, and transmit data from the hospital units to the Management Control unit), or at the Management Control unit itself (e.g., overlapping of different data reporting rules: regional regulations on healthcare reporting information, accountants' logics, professionals' requests). As a resultant, *"the activity registered by the Management Control unit never coincides with the activity that is done at the unit level and that we code and input in our softwares"*, as one clinical director stated and as almost all professionals remarked in the interviews and in the budget negotiation meetings.

However, it should be noted that some professionals, when describing these shortcomings, also acknowledge that the accounting and reporting system is improving anyway:

We should keep in mind that recently the information flows have been improving though, because until a very short time ago we used to receive resounding errors in our unit activity reports: we were negotiating our budget on the basis of resounding errors due to the difficulty in managing data flows within the hospital, between the various units and the central accounting offices.

Second, there is an issue of 'ritualistic' nature of much of the planning course (36 references) that undermines a complete translation of a planning discourse into practice. For example, many professionals agree that the Project management process – although appreciable in its intentions – is not to be taken seriously when it appears that some projects *"are done just to say that you are doing something"* as *"an alibis"*.

Third, there is an issue of 'scarce involvement' of professionals in the planning course (20 references), especially when the Strategic planning process is concerned. A clinical director stated clearly this decoupling between intention and action in the involvement in Strategic planning:

We are involved initially in the presentation phase. Er… There is no bottom-up approach. Or better: there is a lot in theory, because in theory once a year the clinical director tells what he has done in his department and what he plans to do, but then, in the practice…

Involvement of professionals in the strategic planning process is something that characterized the formulation of the past strategic plans, but is also something that faded as long as Strategic planning got established as a practice.

Substantive shortcomings ("You cannot drive a Ferrari if you don't have gas")

Among the substantive shortcomings, one of the most notable ones is the 'lack of human resources' (17 references overall) which is tightly related to 'extra work' (5 references). In other words, especially the Budgeting and the Project management processes are severely constrained by the inadequacy of the human resources (administrative, but also technical and clinical staff of a unit), who are already over-engaged with their tasks.

The Budgeting process, for example, requires a considerable amount of *ad hoc* back office administrative work of routine data entry activity which should be undertaken by some trained staff at every unit. The Direction assures they are making efforts to improve the accounting system, but at the same time requires precision in the data sent by each unit to the Management Control unit. A clinical director commented:

The Direction is now telling us 'garbage in, garbage out', but this sounds like a little blackmail, because we do give data if we have the personnel who can give it. […] So this is the first bottleneck, in my opinion: very often we don't even have administrative staff in our unit for this enormous data entry work; it's often a nurse who takes care of it.

The Project management process too is undermined by similar problems. In the official organizational view projects should be carried out *"all resources being equal"*, in that they should involve a more efficient re-organization of one's work. According to virtually all professionals this is something impossible and it is Project management's most severe shortcoming. A clinical director in an interview exclaimed:

> *'A more efficient re-organization'? Yes, but it's now been ten years that we're re-organizing ourselves! Then, after twenty times that you get re-organized like this or like that, you tell them* [the Directors]: *'I can do this only if you give me ten additional nurses and this machine'. Most of the times the answer is 'It's not true'.*

Indeed, Project management is *"additional work that is not accounted for in the ordinary or extraordinary working hours accounts"*, as a Clinical director specified. Another Clinical director confessed that 4-5 years before his unit used to propose 3-4 projects an year, while *"now we have reduced them to the minimum, because we realized that every project involves additional working hours in fact"*.

A related substantive problem is the 'lack of financial resources' (6 references), especially concerning Project management. The fact that the projects are done by rule "all resources being equal" is a substantive shortcoming that limits the potential of this tool:

> *This is mocking: I propose a project, I take the burden, they weight it in the budget negotiation, but they give me nothing. It's always "all resources being equal"! You cannot do a nice, innovative thing all resources being equal.*

A Clinical director summed up this situation in highly evocative terms:

> *So the invention of the Project management and the Budgeting processes is a double-edged weapon: you cannot drive a Ferrari if you don't have gas! Then OK, I'll give you this engine – the engine could be the quality of human resources – and all the equipment. But if you don't give fuel to all these things to get to the end of the year… you do nothing: if you drive at 300 km/h, but you consume all your gas when you're halfway, what do you do then? You stop? This is what happened.*

Other shortcomings of substantive nature deal with the content of formal planning. A problem of 'complex contents' was referred to by some actors to strategic planning, in particular (10 references). What is mostly lamented is the lengths and the density of the plan that is generally considered *"difficult and complex"*, and made of *"very many objectives, some of which un-readable"* or *"hardly diffusible among the line personnel"*. Indeed, recognizing the complexity of a thick document of almost fifty pages of tables of objectives, the Chief Planning Office itself proposed the

publication of a booklet, as a short of a condensed version of the strategic plan. One doctor made an explicit, critical point on this:

> *Generally in the plan there are indications that are in part practical, and in part generic. I mean, it's not that a plan is good when it has 100 pages. It might have just 2 pages and 4 objectives, but well defined. You cannot set 50 objectives for the main goal of economic savings, for example, because it's obcious that you'll never reach them. It's also a matter of psychology, I think. I mean, not to create frustration, just set one objective, for example […]. Over time there has been a growth in these objectives, but this might also have negative effects, because we cannot follow them up any more.*

Moreover, an issue of 'rhetorical contents' was addressed by some. This was referred especially to the main values stated in the plan (5 references): *"Saying: patient-orientation, the unitedness of the organization, the multi-professional nature… It's quite generic and obvious things"*. But this was also referred to the contents of the projects by some (5 references). A doctor for example stated: *"some projects are fake in terms of content, in that they are meaningless"*. In setting up a new project a doctor noted:

> *I have some perplexities on this project […], meaning that it's the third year that I propose it and it seems a little repetitive to me… It's true that it serves to create a certain mindset… But it also looks a bit ridiculous to me.*

In other words, it emerges that not all initiatives might need to go through the whole project management course, and that sometimes this whole mechanism appears superfluous, but is taken up anyway, like in this case.

All in all, these findings can be summarized as follows. Strategic planning is probably the component of the planning course that is in fact furthest away from professional practice. This might be expected, as strategic planning is something that is typically conceived and carried out at the top management levels of organizations; but it should not be that obvious in a pluralistic organization like Ulss9, that declares strategic planning as a very involving activity (receiving inputs from the basis and pushing professionals to use the contents of the plans in formulating projects and in negotiating the targets of the budget files). Strategic planning does not appear to be diffusedly resisted by professionals (only scant mention is made in this sense). It is even enthusiastically welcomed by some (*"I believe that with strategic planning we have upped our quality"*), and it is clear that the plans are actually read in their contents by some – yet only some – professionals when setting up a new project. Yet, the fact itself that strategic planning tends to be mentioned very little by professionals – compared to project management and budgeting – indicates a perceived greater distance between the strategic planning discourse and professionals' actual

practice. Indeed, most evidence shows that strategic planning is not fully appropriated by professionals. However, interestingly, what is lamented is not its existence or its rationale, rather its contents (considered too complex to be actually handled or too rhetorical to be actually believable), and a scarce actual involvement of professionals in the process.

Project management is very little resisted by professionals. Apparently, professionals show appreciation for this component of the planning course; they conceive it as a tool that enhances collaborations among units, a better organization of work, and an opportunity to rethink about one's work, and they actively engage in it and commit to it in general. A project management discourse seems so not only to have entered clinical practice, but also to have been quite smoothly – if not enthusiastically – absorbed by professionals. However, when it comes to practice, the lack of adequate resources (both human and financial) and the extra not paid work that is entailed by projects undermine a full coupling between the potential of project management and its actual realization. Yet professionals keep engaging with it (and increasingly over time) despite these well recognized shortcomings.

By this time, just like project management, a budgeting discourse is well appropriated by professionals and is not an issue in itself (anymore). It is well accepted as a representation of one's activity and, increasingly, as a tool that enables connecting units and professions and – by all that – governing the activity of a department. But is it really so then in the practice? There is some gap indeed between these premises and the actual flows of action when budgeting is concerned, mainly because of persisting (although diminishing) problems in the information flows and in the accounting representations, and because actual decisions and the actual governance of resources escape the budgeting process in fact.

Discussion

Public sector professional services are increasingly exposed to management tools that are largely imported from private sector management models. The literature on professional organizations has traditionally interpreted these major changes in terms of 'colonization' of a system of values (management) over another (professional practice). In this paper I explored in particular how professionals in a public hospital engage with a formal planning discourse which had been recently introduced in this setting as part of the public sector management reforms. The purpose was to explore whether and how professional practice is being reshaped by formal planning discourses.

I found that the whole planning course (in its manifestations of strategic planning, project management, and budgeting) is a well established repetitive cycle that absorbs indeed many resources and attention at Ulss9. A formal planning discourse pervades the agenda and the local narratives of the clinical professionals (and a project management discourse in particular). But when analyzing how a planning discourse is translated into practice, some incongruence emerges. There are various responses by professionals to the planning course, but there are some patterns that clearly emerge and that allow some interesting reflections. In general, professionals do not respond with hostility to formal planning: they "react with" rather than "against" formal planning.

However, there is some decoupling in fact between the premises of formal planning and actual action flows. Many shortcomings of strategic planning, project management and budgeting emerge: there seem to be some decoupling between what is declared and how decisions and actions actually flow in practice. To put it differently, a full translation of a formal planning discourse into practice is in fact impeded. But what is most interesting is that such decoupling seems not to be due to a mismatch between what people do and their underlying beliefs. In this case no simplistic conflict of beliefs appears to be there (like "managerial" versus "professional" values). Rather, this decoupling seems to derive mainly from shortcomings of organizational nature: procedural (in decisions: lack of control on resources, decisions elsewhere; in other processes: poor accounting system) and substantive (lack of human or financial resources, complex or rhetorical contents).

Decoupling is normally conceived as a gap between intentions and actions due to a mismatch in what people do and what people believe in, resulting in ritual and organizational hypocrisy that leaves the actors' values and beliefs unchanged (Di Maggio, 1988); many studies on the introduction of managerial rationalities in public, professional work recognized patterns of decoupling, also talking about "superficial absorption" (Broadbent & Laughlin, 1997) or "mock ritual" (McGivern & Ferlie, 2007). At Ulss9, somehow surprisingly, in most cases decoupling was not attributable to professionals' scepticism for the planning course: instead, an incomplete translation of a planning discourse into practice seemed due to shortcomings of *organizational* nature, mainly concerning decisional and other processual limits.

One could argue that this finding would echo the critical views of much of the literature on the shortcomings of managerialism, speaking about decoupling between discourse and practice, or about rhetorical rather than effective change, when public sector management reforms are considered, and criticizing the power of managerial reforms in concretely shaping the traditional beliefs and practice in public administrations (Stewart & Walsh, 1992; Gherardi & Jacobsson, 2000; Panozzo, 2000, McNultie & Ferlie, 2004; Zan, 2006). However, this is true only in part: this paper shows the failure of formal planning as a system for formal decision making, but not because of an

immobility of the traditional beliefs in the professional practice; on the contrary, it seems that some changes in the professional practice have taken place, but some organizational processes have not changed accordingly, or at least not completely.

This paper contributes to the literature that has been investigating the introduction of management discourses in public, professional work. First, it extends the debate to a management discourse that was under-explored within this literature (formal planning), hence launching a bridge between two areas of research that have followed parallel evolutions (strategy/planning on the one side, and control/accounting on the other) – a curious academic anomaly when confronted with the empirical reality.

Second, and most importantly, this paper deepens our understanding of the action of managerial discourses, revealing a complex process of structuration of meaning in fact, beyond simplistic dualisms of "profession" versus "management" cultures. Much of the most recent debate had indeed cast attention in overcoming such classic dichotomous representations of professional services and in reassembling professionals as "hybrid" instead (Noordegraaf, 2007, Ezzamel et al ., 2007; Levay & Waks, 2009). However, the findings from this research allow not only going beyond a notion of profession-management conflict (the resistance thesis), but also challenging the notion that "we are all managers now" (Grey 1999) (the hybridization thesis).

Indeed, the introduction of a planning discourse in professional practice and professionals "reacting with" it (instead of "reacting against" it) have substantially changed professional work, but a close scrutiny also showed that professionals are not fully empowered as decision makers, not because of any cultural conflict, but because of several organizational shortcomings. So it is 'post war time' between "profession" and "management", but not because "we are all managers now". Professionals are not, even when they are told they are. Indeed, at Ulss9 a great work on making the planning course meaningful to professionals has been done, and, on the side of professionals, a great work in coping with it, accepting it and re-elaborating it in their own work has been carried out too. The merit can be retrieved in the emphasis set by the Direction through the Planning Office on this process of personnel formation, but also on the nature of clinical work, which is largely based on working by protocols: formal planning can be perceived as a new protocol in the end. Anyway, professionals show to be for the most incline to accept formal planning rationality and have come to the point of even demanding that rationality (clear goals, correct accounts, actual responsibility over resources, etc.) and of growing fatigue when it fails to be so. On the other hand, a fulfilment of this rationality is bounded by several organizational shortcomings (the fact that some decisions escape these formal processes, the fact that information flows are still imperfect in their

vast complexity, the fact that some accounting representations are not meaningful to clinical practice, the scarcity of human and financial resources, etc.). In other words, the cultural change moved faster than the organizational one.

The main implication for research in this field then to closely scrutinize not only what professionals think and do, but also the organizational conditions (actual information flows, actual control, etc.) that might constrain or enable professionals' actual engagement with management tools.

This research focused on 'professional work' in general, without performing a finer grained distinction between different professions (e.g. doctors, nurses, technicians, accountants, etc.), or between different levels (e.g. senior and line staff). Indeed, there could be considerable difference on how different professions or professionals at different positions even in a same organization take up the introduction of a managerial discourse in their work. I could find some hints in this sense in my field experience and some (although still scant) evidence is suggested by the literature too (e.g. Hoque et al., 2004; Jacobs et al., 2004). I did not focus on this distinction since it was not my main interest in this present work. However, this too remains an area to which future research could be directed. Further work could build hence, purposely investigating how professionals' views on formal planning vary (or not) across professions and levels and why.

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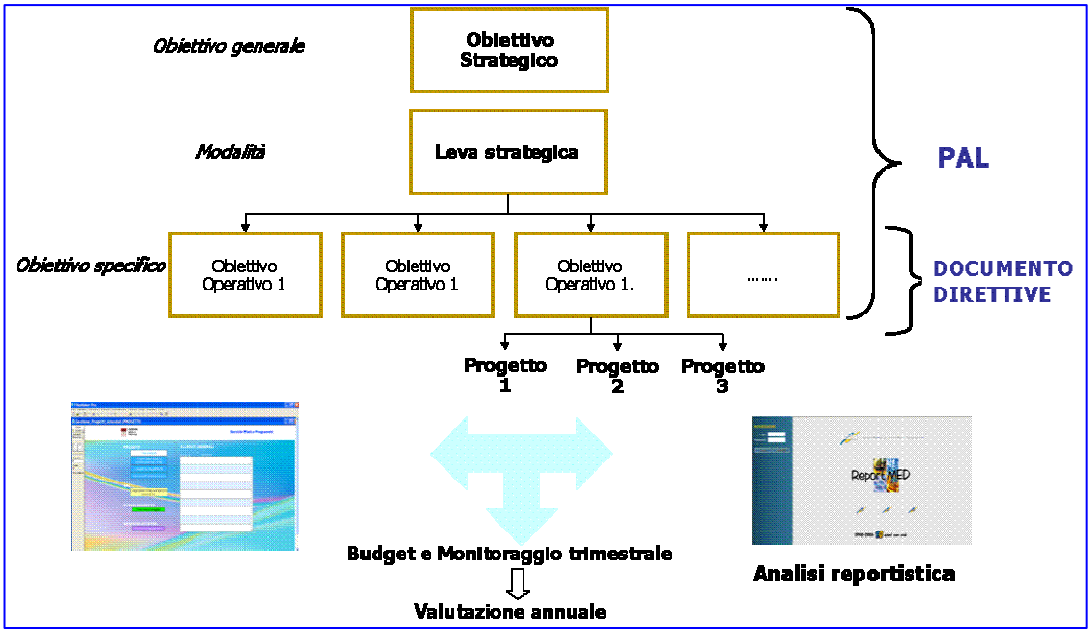
Table 1 - Literature review: Professionals' responses to managerialism

Author	Year	Managerial innovation	Context	Main finding
RESISTANCE				
Laughlin et al.	1992	Accountability	Healthcare	Historical and contextual reasons for professionals' resentment against accountability.
Harrison & Pollitt	1994	Generic	Healthcare	Defensive strategies of clinical directors versus managerial intrusion. "any attempts by general managers to constrain and control doctors resulted in doctors resisting, ignoring or defeating them".
Fitzgerald & Ferlie	2000	Quasi-market	Healthcare	Professionals perceive that their position and freedoms have been eroded and frequently blame 'management' for these changes.
Kitchener	2000	New managerial roles (clinical director)	Healthcare	Doctors taking a clinical director role maintain a strong occupational closure in their medical profession, protect clinical autonomy and resist the managerial colonization over the clinical practice.
Doolin	2002	Restructuring (decentralization)	Healthcare	Lack of change in professionals' sensemaking: identity and sense of their work derived from professionalism and not management.
DECOUPLING				
Whittington et al.	1994	Market changes	Healthcare R&D	Rhetorical appropriation by professionals of a market discourse, but no changes in their practice.
Broadbent & Laughlin	1998	Accountability	Healthcare Education	Superficially absorption of changes.
Fitzgerald & Ferlie	2000	Quasi-market	Healthcare	Some decoupling between the adoption of the budget system and actual decision making processes: professionals weigh issues of cost and have to live within budgets, but tend to give greater weight in many individual decisions to qualità of care and the outcomes of care.
Farrell & Morris	2003	Accountability	Education	Apparent appropriation of accountability innovations, but quite a lot of "game-playing" with new discourses, leaving professional values and autonomy unchanged.
McGivern & Ferlie	2007	Auditing	Healthcare	Professionals 'play tick-box games' to give the impression of auditable practice, while continuing to practise in a traditional way.
HYBRIDIZATION				
Dent 1995)	1995	Quasi-market	Healthcare	Adaptation and development of a new professional autonomy within the quasi-market reorganization of the NHS.
Fitzgerald & Ferlie	2000	Quasi-market	Healthcare	Some clinical directors understand, and empathize with menagerial innovations. For them distinctions between managerial and professional work blur.
Llewellyn	2001	New managerial roles (clinical director). Accountability.	Healthcare	Clinical directors and budgeting mediate between two traditionally distinct representations of the organizational environment (medical versus managerial), building a new, shared view.
Doolin	2001	New managerial roles (clinical leadership).	Healthcare	Growing interpenetration of medical and managerial knowledge. Blurring boundaries between these jurisdictions.
Hoque et al.	2004	Auditing Budgeting	Healthcare	High absrorption of the new managerial culture of managing by goals and targets, but only limited to nurses - not doctors.
Ezzamel et al.	2007	Accountability	Education	Combination and overlapping of a professional and a regulatory (financial) accountability.
Levay & Waks	2009	Auditing	Healthcare	"Soft autonomy", as a combination of non-professional auditing and professional control. The authors confirm the existence of a third way between colonization and decoupling. They find some hybridization through a translation and negotiation work.

Figure 1: Planning course temporal sequence

Source: PAL 2010-2012 power point presentation; Bilancio di Mandato 2008-2009.

Figure 2: Planning course structure



Source: PAL 2010-2012 power point presentation; Bilancio di Mandato 2008-2009.

Table 2 – Analysis: Professionals' responses to formal planning

Cell content: N references

	Plans	Projects	Budget	All tools
Absorption	**10**	**23**	**35**	**68**
1 : Absorption - attitudes	6	10	13	29
2 : Absorption - behaviour	4	13	22	39
Decoupling	**45**	**71**	**125**	**241**
substantive (merit)	*21*	*31*	*20*	*72*
3 : Bureaucracy	0	1	3	4
4 : Complex contents	8	1	1	10
5 : Exrta work	0	4	1	5
6 : Gap between management requests and professional needs	2	3	3	8
7 : Lack of financial resources	0	4	2	6
8 : Lack of human reources	3	8	6	17
9 : Lack of time	1	1	4	6
10 : Politicization	2	4	0	6
12 : Rhetorical contents	5	5	0	10
procedural (method)	*24*	*40*	*105*	*169*
decision realm	4	2	26	32
13 : Decisions elsewhere	2	1	10	13
14 : Lack of control on resources	2	1	16	19
process realm	20	38	79	137
15 : Incentives (ritualistic)	3	5	5	13
16 : Involvement (NOT)	10	6	4	20
17 : Lack of followup	0	2	1	3
18 : Lack of reporting	3	0	0	3
19 : Poor accounting and reporting system	0	7	55	62
20 : Ritualistic behaviour	4	18	14	36
Resistance	**5**	**6**	**6**	**17**
23 : Resistance	5	6	6	17
	60	**100**	**166**	**326**